l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU 00 COMPLET				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155621	A. BUILDING	ì	00	06/16/2	
		100021	B. WING			00/10/2	011
NAME OF F	PROVIDER OR SUPPLIER		ı		OCKER DR		
PINE HA	PINE HAVEN HEALTH AND REHABILITATION CENTER				ILLE, IN47720		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUNDED FOR CROSS-REFERENCED TO THE APP		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	J	DEFICIENCE		DATE
F0000							
	This visit was for	r the Investigation of	F0000	İ	By submitting the enclosed		
	Complaint IN000	_			material we are not admitting		
					truth or accuracy of any spec findings or allegations. We	ific	
	This visit include	ed the Post-Survey			reserve the right to contest th	ie	
		the Investigation of			findings or allegations as par		
	Complaint IN000	088724 completed on			any proceedings and submit		
	April 14, 2011.				these responses pursuant to regulatory obligations. The fa		
					requests that the plan of		
	This visit include	ed the PSR to the			correction be considered our		
	Investigation of 0	Complaints IN00089836,			allegation of compliance effective June 29, 2011 to the complaint survey conducted on June 16, 2011. We respectfully request		
	IN00089626, and	l IN00089748 completed					
	on May 5, 2011.						
					that you review this information		
	•	90882- Substantiated,			request any further information you may require, and then	on	
		iciencies are cited at			consider a desk review.		
	F282 and F323.						
	Survey dates:						
	June 13, 14, 15, a	and 16, 2011					
	Facility number:	000442					
	Provider number						
	AIM number: 10	0266510					
	C						
	Survey team:	m DN TC					
	Anne Marie Cray	/S, KIN-1 C					
	Census bed type:						
	SNF: 38						
	SNF/NF: 61						
	Total: 99						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H3N411

Facility ID:

000442

If continuation sheet

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	E CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED 06/16/2011					
		155621	B. WING	A DDDDGG GIEW GEATE TIN CODE	06/16/2011			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR					
	PINE HAVEN HEALTH AND REHABILITATION CENTER			EVANSVILLE, IN47720				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE				
	Census payor type:							
	Medicare: 20							
	Medicaid: 45							
	Other: 34 Total: 99							
	Total.							
	Sample: 8							
	These deficiencie	es also reflect state						
	findings cited in	accordance with 410 IAC						
	16.2.							
		1 . 1 . 7 . 20						
	Quality review co	ompleted on June 20,						
	2011 by Bev Fau	iikiici, Kiv						
F0282	•	ided or arranged by the						
SS=D		ovided by qualified persons n each resident's written						
	plan of care.	TOGOTTOGIGOTICS WITHOUT						
		ew and record review, the	F0282	F282 It is the practice of Pi	ne 06/29/2011			
		ensure a lap tray utilized		Haven Health and Rehabilitation Center to assure	sure			
	for positioning w	vas placed on a dered by the physician,		that the residents' care plan	าร			
	wheelchan as ord	acted by the physician,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H3N411

Facility ID:

000442

If continuation sheet

Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155621	B. WING		06/16/2011	
en on			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER		3400 S	TOCKER DR		
		REHABILITATION CENTER	EVANS	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	for 1 of 4 residen	its reviewed for falls, in a		are followed appropriately	l l	
	sample of 8. Res	sident A		accordance with the asses		
				needs. The corrective action		
	Findings include			taken for those residents f		
	I mamgs meraue	•		to be affected by the defici practice include: Resident	I	
	The distinct mass	and a CD and A area		no longer a resident of the fa	• • • • • • • • • • • • • • • • • • •	
		ord of Resident A was		Other residents that have t	•	
		3/11 at 11:20 A.M.		potential to be affected have		
	Diagnoses includ	led, but were not limited		been identified by: All resid	• • • • • • • • • • • • • • • • • • •	
	to, Dementia, Par	rkinson's disease, and		have been reviewed to assu		
	Epilepsy. A Physician's order, dated 4/15/11,			that they are receiving servi	ces in	
				accordance with the plan of	I	
				The CNA assignment sheets	I	
	1 -	y use deluxe tray [with]		appropriately address reside	I	
				needs based on the assessi		
	_	mps to w/c to aide [sic]		and a monitoring system had been implemented to assure	I	
	in positioning du	e to poor posture."		interventions are appropriate	I	
				place. The measures or	51y 111	
	A Care Plan, init	ially dated 5/23/09 and		systemic changes that hav	re	
	updated 4/15/11.	indicated a problem of		been put into place to ensi	l l	
		ls R/T [related to]:		that the deficient practice (does	
		d unassisted. History of		not recur include: The		
	1 *	•		interdisciplinary team will be	I	
	1 -	oses balance easily.		reviewing every fall to assur		
	1	'The Interventions		appropriate interventions are		
		1 Deluxe tray [with]		place based on the possible cause of the fall. The plan of	• • • • • • • • • • • • • • • • • • •	
	Quick release cla	imps to w/c to aide [sic]		care and the CNA assignme	I	
	in positioning d/t	[due to] poor posture."		sheets will be updated as	""	
	Y and the second of the second			needed. The nursing staff h	as	
	Nurse's Notes da	ated 4/25/11 at 2:35		again been in-serviced relate	I	
		"Gotten up in w/c in TV		providing services to our		
		oise resident had fallen		residents in correlation with		
	1 ~			written plan of care. In addi	•	
		aceration to forehead		there will be additional empl	nasis	
	1 - 11	3 cm [centimeters]		for new CNA's related to	shooto	
	length, width line	ear 0.1 cm edges		reviewing their assignment so that they are aware of the		
	approximated [ar	nd] steri striped [sic]		of care established for the	ριαπ	
	1 ^ ^	Small am't [amount]		resident. There will be routing	ne	

FORM APPROVED OMB NO. 0938-0391

PRINTED:

07/06/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155621 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3400 STOCKER DR PINE HAVEN HEALTH AND REHABILITATION CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE monitoring via rounds by nurses bleeding from nose...Has red bruise area and nursing administration to [approximately] 2 cm diameter on [right] assure that safety devices are in knee...." place and functional in accordance with the residents' plans of care. The corrective On 6/13/11 at 12:15 P.M., the ADON action taken to monitor (Assistant Director of Nursing) provided performance to assure an "Incident/Accident Report," dated compliance through quality 4/25/11. The report included: "...Resident assurance is: A Performance attempting to get up unassisted several Improvement Tool has been initiated that will be utilized to times wanting to get up...resident gotten randomly review 5 residents' up per CNA in w/c, placed in TV comprehensive assessment in lounge...Heard noise, resident on floor, correlation with the plan of care to w/c in normal position...Additional assure that the pertinent information based on the comments and/or steps taken to prevent assessment is accurately recurrence: Education to new staff communicated and being importance of CNA assignment sheet to followed in accordance with the keep on @ all times...." During interview residents' identified needs. Safety device placement and function at that time, the ADON indicated he was will be specifically identified on not employed by the facility on 4/25/11, the monitoring form. Nursing and did not have additional information. Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any On 6/16/11 at 6:25 A.M., during interview areas identified via the audit will with RN # 1, she indicated she was the be immediately corrected. The nurse working when Resident A fell on **Quality Assurance Committee will** 4/25/11. RN # 1 indicated a "new CNA" review the tool at the scheduled meeting following the completion transferred the resident to a wheelchair, of the tool with recommendations and did not place the lap tray on the as needed. The date the wheelchair as ordered. systemic changes will be completed: 6-29-11 This federal tag relates to Complaint IN00090882. This deficiency was cited on 4/14/11. The facility failed to implement a systemic

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 5/2011	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			3400 S	ADDRESS, CITY, STATE, ZIP TOCKER DR WILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIEN REGULATORY OR	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETION

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155621 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3400 STOCKER DR PINE HAVEN HEALTH AND REHABILITATION CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must ensure that the resident F0323 environment remains as free of accident SS=D hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. F323 It is the practice of Pine Based on interview and record review, the F0323 06/29/2011 Haven Health and facility failed to ensure a lap tray utilized **Rehabilitation Center to assure** for positioning was placed on a that the resident environment wheelchair, causing the resident to fall remains as free of accident and obtain a laceration on her forehead, hazards as possible, and each for 1 of 4 residents reviewed for falls, in a resident receives adequate supervision and assistance sample of 8. Resident A devices to prevent accidents. The corrective action taken for Findings include: those residents found to be affected by the deficient practice include: Resident #A no The clinical record of Resident A was longer resides at the facility. reviewed on 6/13/11 at 11:20 A.M. Other residents that have the Diagnoses included, but were not limited potential to be affected have to, Dementia, Parkinson's disease, and been identified by: All residents Epilepsy. have been reviewed to assure that they are receiving services in accordance with the plan of care An annual Minimum Data Set [MDS] and assessed safety devices. assessment, dated 3/19/11, indicated The CNA assignment sheets Resident A had a short-term and appropriately address residents' needs based on the assessment long-term memory problem, was and a monitoring system has moderately impaired in cognitive skills been implemented to assure that for daily decision-making, was interventions are appropriately in non-ambulatory, and required extensive place. The measures or systematic changes that have assistance of one staff for transfer. been put into place to ensure that the deficient practice does A Physician's order, dated 3/31/11, not recur include: The indicated, "OT [occupational therapy] interdisciplinary team will be eval [evaluation] only for evaluation of reviewing every fall to assure that appropriate interventions are in improvent [sic] of positioning in w/c place based on the possible [wheelchair] (extreme leaning forward)."

000442

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155621	B. WIN			06/16/20)11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			TOCKER DR		
PINE HA	PINE HAVEN HEALTH AND REHABILITATION CENTER			1	VILLE, IN47720		
		_		VILLE, IIV-7720			
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG		_	DATE
					cause of the fall. The plan o		
	An OT note, date	ed 4/1/11, indicated,			care and the CNA assignment sheets will be updated as	nt	
	"Reason for Re	eferral:multiple medical			needed. The nursing staff ha	as	
	complexities affe	ecting positioning in			again been in-serviced relate		
	_	eral weakness and			providing services to our		
	1	requiring OT intervention			residents in correlation with t	:he	
	1	ning and decreased safety			written plan of care. In addit		
					there will be additional emph	asis	
	in wheelchair'	•			for new CNA's related to		
	A Physician's order, dated 4/15/11, indicated, "May use deluxe tray [with]				reviewing their assignment s		
					so that they are aware of the of care established for the	pian	
					resident. There will be routing	ne	
	quick release cla	mps to w/c to aide [sic]			monitoring via rounds by nur		
	1 -	ie to poor posture."			and nursing administration to		
	in positioning the	to poor postare.			assure that safety devices ar		
	A Come Dlam init	ially dated 5/22/00 and			place and functional in		
		tially dated 5/23/09 and			accordance with the resident		
	_	indicated a problem of			plans of care. <i>The corrective</i>	e	
		ls R/T [related to]:			action taken to monitor		
	Attempts to stan	d unassisted. History of			performance to assure	_	
	previous falls. L	oses balance easily.			compliance through quality assurance is: A Performance		
	Unsteady gait	" The Interventions			Improvement Tool has been	·E	
		11 Deluxe tray [with]			initiated that will be utilized to	,	
		amps to w/c to aide [sic]			randomly review 5 residents		
		t [due to] poor posture."			comprehensive assessments		
	in positioning u/	t [due to] poor posture.			correlation with the plans of	care	
		1.405(11			to assure that the pertinent		
		ated 4/25/11 at 2:35			information based on the		
		"Gotten up in w/c in TV			assessments is accurately		
	lounge. Heard no	oise resident had fallen			communicated and being followed in accordance with	the	
	out of w/c. Has 1	aceration to forehead			residents' identified needs. S		
	[approximately]	3 cm [centimeters]			device placement and function	, ,	
		ear 0.1 cm edges			will be specifically identified		
	_	nd] steri striped [sic]			the monitoring form. Nursing		
					Administration, or designee,		
		Small am't [amount]			complete this tool weekly x3		
	1	oseHas red bruise area			monthly x3, then quarterly x3		
[approximately] 2 cm diameter on [right]				areas identified via the audit	will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MUI A. BUILE B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 06/16/2	LETED	
	NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET A	DDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		P	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	kneeDenies panoseAssisted be [two]." The resident was hospital on 4/25/returned the same the steri strips learners ident's forehead on 6/13/11 at 12 (Assistant Direct an "Incident/Acc 4/25/11. The repeattempting to get times wanting to up per CNA in welloungeHeard new work in normal procomments and/or recurrence: Education importance of Clause on @ all times at that time, the process of the comployed by and did not have on 6/16/11 at 6.2 with RN # 1, she nurse working we 4/25/11. RN # 1 transferred the resident was sistent as the complex of the	transferred to the 11 at 4:00 A.M., and e day at 7:10 A.M., with ft in place on the ad. 15 P.M., the ADON or of Nursing) provided ident Report," dated ort included: "Resident to up unassisted several get upresident gotten e/c, placed in TV oise, resident on floor, sitionAdditional or steps taken to prevent eation to new staff NA assignment sheet to nes" During interview ADON indicated he was the facility on 4/25/11, additional information. 25 A.M., during interview indicated she was the hen Resident A fell on indicated a "new CNA" esident to a wheelchair, the lap tray on the			be immediately corrected. Quality Assurance Commit review the tool at the sched meeting following the comp of the tool with recommend as needed. The date the systemic changes will be completed: 6-29-11	ee will luled letion	

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155621		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011	
	NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			ADDRESS, CITY, STATE, ZIP (TOCKER DR VILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Director of Nurs current facility p Prevention," date included: "Policy are safe and that measures are init injuries related to This federal tag IN00090882. This deficiency of facility failed to	ed 9/08. The policy y, To ensure that residents appropriate preventive tiated to minimize				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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l		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 06/16/2	LETED
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			3400 S	ADDRESS, CITY, STATE, ZIP O TOCKER DR SVILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

Facility ID: